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Supreme Court, U.S.
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No. 95-1166

In The

Supreme Court of the United States

October Term, 1995

NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIENDS AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J. N. MCDONALD, JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT COMPANY,

Petitioners,

versus

PROVIDENT INDEMNITY LIFE INSURANCE COMPANY, ET AL.,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. McDonald Equipment Company ("McDonald Equipment") subscribed to a group health plan for its employees and their dependents (including Petitioners) through The Business Insurance Trust (the "BIT") in 1986, and the group health plan was underwritten by a group health policy issued by North Carolina Mutual Insurance Company ("NCM") and later by a group health policy issued by Provident Indemnity Life Insurance Company ("PILIC"). Arden French ("French") was the trustee of the BIT at all relevant times. Did the lower courts err in holding that the group health plan was an employee welfare benefit plan within the scope of the Employee Retirement Income Security Act of 1974, 28 U.S.C. § 1001, *et seq.* ("ERISA")?

2. Did the lower courts err in holding that Petitioners' state law claims sufficiently "relate to" the group health plan so the claims would be preempted by ERISA?

3. When McDonald Equipment originally subscribed to the group health plan, the group health plan was underwritten by a group health policy issued by NCM, and Insurance Resource Management ("IRM") (an administration company organized by French) was the third-party administrator for the plan. When NCM later indicated that it would be terminating the group health policy, French (as trustee of the BIT) sought to obtain replacement group health coverage, and he ultimately placed the coverage

QUESTIONS PRESENTED – Continued

with PILIC. PILIC's policy was a typical group health policy, and PILIC periodically adjusted premiums based upon an employer's loss history according to a tier-rating schedule (which was common in the industry). Did the lower courts err in finding that French (as trustee of the BIT) did not breach any fiduciary duties in placing the replacement coverage with PILIC?

4. Contrary to Petitioners' assertions, Respondents did not act as an insurance agent or broker for the group health plan, and Petitioners did not assert claims against Respondents in such capacity. Rather, Petitioners sued PILIC (as the insurer which underwrote the group health plan), French (as trustee of the BIT), and the BIT (the multiple employer trust through which Petitioners obtained coverage under the group health plan). Did the lower courts err in holding that Respondents (in such capacities) were ERISA fiduciaries?

5. Did the lower courts err in holding that there was no breach of fiduciary duty relating to the adjustment of premiums and handling of claims that resulted in a "loss to the plan" as required under ERISA?

LIST OF INTERESTED PERSONS OR ENTITIES

The following parties have an interest in the outcome of this case:

1. Nathan and Sharyl McDonald, Individually and as next Friends and Guardians of Nathan Neil McDonald, a Minor, and J. N. McDonald, Jr., Individually and d/b/a McDonald Equipment Company

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2. Provident Indemnity Life Insurance Company, Arden O. French, Jr., Trustee for The Business Insurance Trust and The Business Insurance Trust

   Represented by **Gene F. Creely, II**
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3. Provident American Corporation (parent company of Provident Indemnity Life Insurance Company)

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French (as trustee of the BIT) did not breach any fiduciary duty in placing the replacement coverage with PILIC 22

Neither PILIC nor French breached any fiduciary duty to Petitioners relating to the setting of premiums or in the handling of the group health plan 26

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NOW COME Respondents PROVIDENT INDEMNITY LIFE INSURANCE COMPANY ("PILIC"), ARDEN O. FRENCH, JR. ("French"), AS TRUSTEE OF THE BUSINESS INSURANCE TRUST, and THE BUSINESS INSURANCE TRUST (the "BIT") (collectively, "Respondents") and submit this Brief in Opposition to Petition for Writ of Certiorari filed on behalf of Petitioners NATHAN AND SHARYL MCDONALD, INDIVIDUALLY AND AS NEXT FRIENDS AND GUARDIANS OF NATHAN NEIL MCDONALD, A MINOR, AND J. N. MCDONALD, JR., INDIVIDUALLY AND D/B/A MCDONALD EQUIPMENT COMPANY (collectively, "Petitioners").

REFERENCE TO OPINION BELOW

The Opinion of the United States Court of Appeals for the Fifth Circuit has been reported at *McDonald v. Provident Indemnity Life Ins. Co.*, 60 F.3d 234 (5th Cir. 1995). The Opinion of the United States District Court for the Southern District of Texas, Galveston Division, has not been published in the Federal Reporters.

STATEMENT OF JURISDICTION

The District Court rendered its Final Judgment on June 3, 1993. On appeal, the Fifth Circuit Court of Appeals rendered its Opinion on August 9, 1995. Petitioners timely filed their Motion for Rehearing, and the motion was denied on September 15, 1995. Petitioners submitted a Petition for Writ of Certiorari on December 14, 1995, which was not filed until January 22, 1996, after Petitioners' counsel was admitted to the bar of this Court.

In their Petition, Petitioners "invoke the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1)," and they suggest that this Court should grant the Petition to consider an alleged "split of authority" between courts of appeals relating to ERISA preemption of state law claims regarding fraudulent inducement by an insurance agent to participate in an "ERISA plan." Petitioners also suggest that there is an alleged "split of authority" between courts of appeals regarding the "status and duties of a fiduciary."

However, Petitioners have failed to "present with accuracy, brevity and clearness whatever is essential to a ready and adequate understanding of the points requiring consideration," and such failure is "sufficient reason for denying the petition." Supreme Court Rule 14.5. Petitioners also have failed to raise "special important reasons" for the granting of the Petition for Writ of Certiorari. Supreme Court Rule 10.1.

In any event, there is no "split of authority" between Courts of Appeals relating to the facts of this case (as suggested by Petitioners). Petitioners did not assert any claim of fraudulent inducement against an insurance agent, and there was no fraud perpetrated by Respondents (as suggested by Petitioners) that induced Petitioners into participating in the group health plan.

Excluding Petitioners' ERISA claims, Petitioners have not asserted any claims under federal law; Petitioners' state law claims clearly "relate to" the administration of an employee welfare benefit plan governed by ERISA; and, thus, Petitioners' state law claims would be preempted by ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1558 (1987).

Regarding Petitioners' ERISA claims, there was no breach of fiduciary duties by Respondents through the group health plan, and Petitioners failed to prove a "loss to the plan" as required by 29 U.S.C. § 1109(a). *See Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. 3085, 3089-3090 (1985). Also, Petitioners have not alleged that the Court of Appeals erred in holding that they failed to prove any "loss to the plan"; and, thus, Petitioners have failed to present this issue to this Court for review. *See Chandris, Inc. v. Latsis*, 115 S.Ct. 2172, 2182 fn. 1 (1995); *Kamen v. Kemper Financial Services, Inc.*, 111 S.Ct. 1711, 1716 fn. 4 (1991) (Ordinarily, the Supreme Court should not consider an issue that a Petitioner fails to raise in a Petition for Writ of Certiorari).

Accordingly, this Court should decline to exercise jurisdiction by granting the Petition for Writ of Certiorari in this case.

LIST OF RELEVANT STATUTES

Respondents assert that the following statutes are relevant to this Court's consideration of the issues in this case:

29 U.S.C. § 1002(1)

29 U.S.C. § 1104(a)

29 U.S.C. § 1109

29 U.S.C. § 1132(a)(1)

29 U.S.C. § 1144(a)

The statutes are quoted *verbatim* in Appendix I.

Contrary to Petitioners' assertions relating to "Constitutional and Statutory Provisions at Issue," neither the Texas Deceptive Trade Practices - Consumer Protection

Act ("DTPA"), § 17.46 *et seq.* of the Texas Business & Commerce Code, nor Article 21.21 of the Texas Insurance Code (cited by Petitioners) is relevant because Respondents did not commit any violations of these statutes, and ERISA preempts Petitioners' claims thereunder since the claims clearly "relate to" the administration of an employee welfare benefit plan governed by ERISA. Also, the federal "mail fraud statute," 18 U.S.C. § 1001 (cited by Petitioners), is not relevant because Petitioners did not assert any claim of "mail fraud" or "wire fraud" under the statute, and Respondents did not commit any "mail fraud" or "wire fraud." In addition, there was no "self dealing by alleged ERISA fiduciaries" in this case; and, thus, 29 U.S.C. § 1106 (cited by Petitioners) is also not relevant.

STATEMENT OF THE CASE

Relevant history of the group health plan.

The Business Insurance Trust (the "BIT") (a multiple employer trust) was established in 1968 as a vehicle for allowing small businesses (like McDonald Equipment Company ("McDonald Equipment")) to obtain group health coverage. (Tr.II 162-164; *see* Tr.I 96) Originally, Arden French ("French") was the trustee of the BIT (a dry trust which had a group health policy as its only asset) (Tr.II 127, 285), the group health plan was underwritten by group health policies issued by various insurers, and the insurers delegated the administration of the group health plan to Insurance Resource Management ("IRM") (an administration company organized by French) as a third-party administrator. (Tr.II 55-58, 163-167) IRM administered the BIT according to guidelines/procedures

specified by the insurer providing the coverage which underwrote the group health plan. (Tr.II 49) The BIT (a multiple employer trust) is a fairly common arrangement (Tr.II 253); it is not uncommon for the trustee (such as French) of a multiple employer trust to also own the administration company which administers the multiple employer trust (*Id.*); and this is a perfectly legitimate arrangement which is not proscribed in any state. (Tr.II 270)

In 1986, McDonald Equipment subscribed to the group health plan for its employees and their dependents (including Petitioners) through the BIT. (Tr.I 38) At the time of the subscription, the group health plan was underwritten by a group health policy written by North Carolina Mutual Insurance Company ("NCM") (*Id.*), and IRM continued to act as the third-party administrator of the group health plan. (Tr.I 49) Under the group health plan, McDonald Equipment paid the premiums for its employees and part of the premiums for their dependents (Tr.I 55), and the premiums for McDonald Equipment's group health coverage were adjusted every six months according to a class or tier re-rating structure. (Tr.I 233-235; Tr.II 61-63, 88-90) At the time of the subscription, Nathan McDonald (Manager of McDonald Equipment) acknowledged that **"this is a variable re-[r]ated trust which allows cases to be rated on a class basis based on claims experience, history, census data, medical costs, area rating, industry classification and health condition."** (Bold in original) (Ex. 3; Tr.I 76, 120)

During the relevant time, the premiums for group health coverage were commonly adjusted periodically according to a tier re-rating structure throughout the insurance industry. (Tr.II 90, 168, 180-181) Under a tier re-

rating structure, participating employers received premium increases periodically based upon whether their respective claims histories fell into certain pre-determined ranges of loss ratios (or tiers) for the preceding rating period. (Tr.II 88) The setting of the ranges of loss ratios and premium increases is determined by actuaries according to various factors including census data, medical costs, area rating, industry classification, health conditions and claims experience for the entire block of business (i.e., all of the participating employers in the group health plan). (Tr.II 171-172, 275)

In 1988, NCM notified French (as trustee for the BIT) that it intended to cancel its group health coverage which underwrote the group health plan. (Tr.II 172) Faced with this "emergency" situation, French was required to go into the marketplace and search for available replacement group health coverage, or else the participating employers (including McDonald Equipment) would be left without any group health coverage for their employees and their dependents. (Tr.II 70-71, 173-175; *see* Tr.II 208, 230, 245-246) French's main concern was to obtain replacement coverage for these employer groups. (Tr.II 208, 238) French contacted several interested insurers including Provident Indemnity Life Insurance Company ("PILIC"); he personally met with representatives of PILIC; he felt that PILIC (a solvent company with 102-year history) provided the best available replacement group health coverage under the circumstances; and, he placed the replacement group health coverage with PILIC effective August 1, 1988. (Tr.II 179-180, 229, 279)

French (as trustee of the BIT) had very limited duties which primarily involved insuring that appropriate coverage was maintained and holding the master policy for

the benefit of the participating employer groups. (Tr.II 168, 285) It is undisputed that French had no prior relationship with PILIC (Tr.II 175), and he received no remuneration or consideration for the placement of the replacement group health coverage with PILIC. (Tr.II 176)

In the health industry, there are rarely identical group health policies provided by different insurers. (Tr.II 180, 277) However, the PILIC group health policy provided substantially similar coverage to the group health coverage under the preceding NCM policy. (Tr.II 276; *see* Tr.II 146-159, 193-198, 281; *compare* Ex. 1 and Ex. 2) Both policies provided the same basic major medical benefits (with only minor differences), and the policy limits and deductibles were the same. (*Id.*) Also, the premiums for the group health coverage under the PILIC policy were to be adjusted based upon a participating employer's claims history under a tier re-rating structure in "basically the same way" that premiums were adjusted for group health coverage under the NCM policy. (Tr.II 61, 80, 180, 223; *see* Tr.I 194)

French had no responsibility for pricing/re-rating of premiums for group health coverage under the group health plan. (*See* Tr.I 219) Rather, re-rating (which is actuarially determined) was solely within the province of the insurer which underwrote the group health plan. (*Id.*) Also, information about the basis for re-rating premiums was customarily not furnished to covered persons, as such information is proprietary and there are a number of practical reasons why such information is not customarily disclosed (*e.g.*, an insurer may change its re-rating structure, the insurer may cancel its group coverage and a

succeeding insurer may adopt a different re-rating structure, any disclosure would defeat an insurer's competitive advantage since re-rating is determined in the free market, agents might be subject to liability for disclosure, etc.). (Tr.II 105, 224-225; Tr.III 2-3)

After PILIC began underwriting the group health plan, the premiums for the group health coverage were adjusted every six months according to a tier re-rating structure (as they had been adjusted in the past when the group health plan was underwritten by the NCM policy) (Tr.II 105, 224-225; Tr.III 2-3), and McDonald Equipment began receiving periodic increases in the premiums for the group health coverage for its employees and their dependents upon such basis (as they had been adjusted in the past when the group health plan was underwritten by the NCM policy). (Tr.I 72)

On September 15, 1989, Neil McDonald (the minor child of Nathan and Sharyl McDonald) suffered injuries in a near-drowning accident (Tr.I 40), and Petitioners incurred substantial medical expenses for the treatment of their minor child following the accident. (*See, e.g.*, Tr.II 151) Based upon the claims history of McDonald Equipment (which included the medical expenses for Neil McDonald), the premiums for McDonald Equipment's group health coverage for its employees and their dependents under the PILIC policy were subsequently adjusted under the class or tier re-rating structure (as they had previously been adjusted in the past). (Tr.I 79-80)

Shortly after the accident, French ceased to be the trustee of the BIT in November 1989, and his limited duties as trustee were transferred to three individuals and subsequently to TrustMark Bank of Jackson, Mississippi. (Tr.II 122-124, 183) Also, the situs of the BIT was

transferred from Georgia to Mississippi. (Tr.II 116) At this time, PILIC also acquired the business under the BIT which had been handled by IRM (the administration company organized by French) in exchange for a certain amount of cash, shares of Provident American Corporation (the parent company of PILIC) and a small overriding royalty on future premiums; and, the administrative responsibilities of the group health plan were transferred from IRM to in-house at PILIC. (Tr.II 182-187) French later became a director of Provident American Corporation (the parent company of PILIC). (Tr.II 21)

The timing of the transfer of the trustee duties, the transfer of the administration of the group health plan and the transfer of the situs of the BIT (approximately two months after the subject accident) was merely coincidental, since French was unaware of the subject accident at the time. (Tr.II 188) Also, the transfer of the trustee duties, the transfer of the administration of the group health plan and the transfer of the situs of the BIT did not effect any change in the group health coverage under the PILIC policy or any change in the handling of claims under the PILIC policy. (Tr.II 184-186, 284)

The first post-accident premium adjustment for McDonald Equipment occurred in February 1990, with subsequent adjustments in August 1990 and February 1991. (Tr.I 79-80, 283) Following these adjustments, McDonald Equipment made the conscious decision to discontinue paying premiums for the group health coverage for its employees and dependents under the group health plan in February or March 1991 (Tr.I 41, 66); and, McDonald Equipment's group health coverage for its employees and their dependents terminated effective

March 31, 1991 as a result of non-payment of premiums. (Tr.I 64; Tr.II 145)

It is undisputed that PILIC paid approximately $360,000.00, which represented all benefits for claims under the PILIC policy for covered medical expenses incurred by Petitioners through March 31, 1991 (the date of termination of coverage).[1] (Ex. 41; Tr.II 145; *see* Tr.I 64, 119, 174)

Relevant history of this litigation.

Subsequently, Petitioners filed this lawsuit against PILIC, French (as trustee of the BIT) and the BIT relating to the placement of the group health coverage with PILIC, the adjustment of premiums and the handling of claims under the group health plan. (R.I 1-6) Petitioners alleged various claims under state law (including claims of breach of contract, breach of fiduciary duty, breach of the duty of good faith and fair dealing, fraud and violations of the Texas Deceptive Trade Practices – Consumer Protection Act ("DTPA") and Article 21.21 of the Texas Insurance Code). (*Id.*) (R.III 434-462) In the alternative, Petitioners alleged claims under ERISA. (*Id.*)

Before trial, the District Court granted partial summary judgment that the group health plan was an employee welfare benefit plan within the scope of ERISA and that Petitioners' state law claims were preempted by

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[1] At the time of the termination of the coverage (due to nonpayment of premiums), there were potentially $640,486.90 in remaining limits for benefits over the lifetime of Neil McDonald. (Tr.II 33) However, those remaining limits ceased to be available to Petitioners upon the termination of coverage. (Ex. 1)

ERISA. (R.III 695-702) After the conclusion of trial, the District Court rendered Findings of Fact and Conclusions of Law in favor of Respondents. (R.IV 936-947) Basically, the District Court found that (1) French (as trustee of the BIT) did not act arbitrarily and capriciously in the placement of the group health coverage with PILIC, (2) neither PILIC nor French (as trustee of the BIT) breached any fiduciary duties relating to the setting of premiums or the handling of the administration of the group health plan and (3) thus, Respondents were not liable to Petitioners for damages under ERISA. (*Id.*) Accordingly, the District Court rendered a Final Judgment for Respondents. (R.IV 949)

On appeal, the Fifth Circuit Court of Appeals affirmed. In pertinent part, the Court of Appeals held that (1) McDonald Equipment's subscription to the group health plan through the BIT (a multiple employer trust) constituted an employee welfare benefit plan governed by ERISA, (2) Petitioners' state law claims were preempted by ERISA, (3) French did not breach any fiduciary duty in the placement of the group health coverage with PILIC, and (4) even if French had a duty to disclose the PILIC re-rating schedule, Petitioners failed to prove any "loss to the plan" as a result of such nondisclosure as required by 29 U.S.C. § 1109(a). *McDonald v. Provident Indemnity Life Ins. Co.*, 60 F.3d 234, 235-238 (5th Cir. 1995).

REASONS WHY THE PETITION SHOULD BE DENIED

The group health plan constituted an employee welfare benefit plan under ERISA, and Petitioners' state law claims are preempted under ERISA.

ERISA defines an employee welfare benefit plan as follows:

> . . . any plan, fund or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1). By its terms, ERISA encompasses employee welfare benefit plans provided through the purchase of insurance. *Id.* Moreover, it is common practice for employers to provide health benefits to their employees through the purchase of group health policies from commercial insurers (such as PILIC). *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240 (5th Cir. 1990). Furthermore, a formal document designated as "the plan" is not required to establish that an employee welfare benefit plan provided through the purchase of insurance under ERISA exists. *Id.* at 241.

An employee welfare benefit plan under ERISA is established and maintained "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *See Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1452 (5th Cir. 1991); *Memorial Hospital System*, 904 F.2d at 240, quoting

Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*).

Contrary to Petitioners' assertions, the group health policy issued by PILIC clearly was "insurance"[2] and, the group health plan (which was underwritten by the PILIC policy) qualified as an employee welfare benefit plan under ERISA, since McDonald Equipment intended to provide health benefits through the group health plan for its employees and their dependents. *Id.*

Specific health benefits were provided to a class of beneficiaries – the employees and dependents of McDonald Equipment. (*Id.*; *also*, R.II 299) Also, the source of financing was provided by McDonald Equipment

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[2] The group health policy issued by PILIC was a basic comprehensive major medical health insurance policy (Ex. 1; Tr.II 170, 179). At trial, Joe Hawkins (a former Commissioner of the State Board of Insurance of Texas) confirmed that the PILIC policy constituted insurance. (Tr.II 273) Robert Jaffe (Petitioners' insurance agent) also confirmed that the PILIC policy was insurance (Tr.I 108) Furthermore, it is clear that, assuming Petitioners' definition of insurance as "a spreading of the risk," the PILIC policy constituted insurance. (*See* Tr.I 224-228) The evidence shows that, although McDonald Equipment paid a few thousand dollars a month in premiums for post-accident group health coverage for its employees and their dependents (including Neil McDonald), PILIC paid approximately $360,000 in medical benefits for Neil McDonald alone (Tr.I 189; Tr.II 271).

Also, several witnesses discussed the inherent fairness and reasonableness of tier re-rating as a basis for periodic adjustment of premiums for group health coverage. (Tr.II 190, 271-272) In addition, tier-rating does not allow an insurer to recoup all claims paid (as suggested by Petitioners) (Tr.II 271) Furthermore, the group health coverage afforded by PILIC did "protect" Petitioners against this "large loss" (contrary to Petitioners' assertion). (*See* Tr.II 189, 271)

(which paid the premiums for its employees and a substantial portion of the premiums for their dependents through payroll deductions). (*Id.*) *See Memorial Hospital System*, 904 F.2d at 241 (where the employer contributed one-half of the total premium through payroll deductions, clear intent was found on the employer's part to provide its employees with a welfare benefit plan). *See also Randol v. Med-West National Life Ins. Co. of Tennessee*, 987 F.2d 1547 (11th Cir. 1993); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991). In addition, the record clearly shows that McDonald Equipment (as employer) determined the benefits to be offered (including the decision to raise the deductible for the group health coverage from $100 to $500 following the first post-accident premium adjustment) (R.II 282-283, 296, 307); McDonald Equipment undertook the responsibility for notifying PILIC of employees who should be added or deleted from the group health plan (R.II 288-290, 300); and, McDonald Equipment provided enrollment forms to new employees. (R.II 302) Moreover, the procedure for claiming benefits required employer involvement in the group health plan. Nate McDonald (manager of McDonald Equipment) was responsible for coordinating the participation of the employees of McDonald Equipment and their dependents in the group health plan (R.II 286-288, 301); management was responsible for distributing wallet identification cards, enrollment and claim forms (R.II 284, 288-290, 297-298, 300, 302); and, furthermore, the section "How to File a Medical Claim" found in the PILIC insurance certificate requires portions of any claim form to be completed by both the employer and employee (R.II 418), and PILIC

also required McDonald Equipment (as employer) to verify the employment and dependency status of individuals applying for benefits (R.II 288-290, 300).

Petitioners assert that J. N. McDonald (the owner of McDonald Equipment) understood that McDonald Equipment merely "bought an insurance policy with competitive rates" and that there was no intention to establish or maintain an employee welfare benefit plan under ERISA, and McDonald Equipment did not comply with any ERISA reporting requirements. However, McDonald Equipment's subjective intent and its noncompliance with the ERISA reporting requirements are irrelevant to the determination of the existence of an employee welfare benefit plan under ERISA. The "test of whether a benefit plan is exempt from ERISA is not one of the employer's motivation" and "an employer cannot 'opt out' of ERISA by noncompliance." *Marshall v. Bankers Life and Casualty Co.*, 832 P.2d 573, 581 (Cal. 1992) (*en banc*), citing *Shaw v. Delta Airlines, Inc.*, 103 S.Ct. 2890-2905 (1983). Rather, the existence of an employee welfare benefit plan under ERISA is to be determined by the surrounding facts and circumstances (not by statements of an employer's subjective intent) according to the relevant factors articulated in the *Gahn, Memorial Hospital System* and *Donovan* cases. *See Randol*, 987 F.2d at 1549 (applying *Donovan* factors, group health coverage purchased by an employer for his employees was an employee welfare benefit plan governed by ERISA despite the employer's testimony that he did not intend to create an ERISA plan, and he did not comply with any ERISA reporting requirements); *International Resources*, 950 F.2d at 297 (applying *Donovan* factors, group health coverage purchased by an employer for his

employees was an employee welfare benefit plan governed by ERISA despite the employer's contention that he did not intend to create an ERISA plan).

Petitioners also assert that a multiple employer trust is not an employee welfare benefit plan under ERISA and that, since the group health plan involved a multiple employer trust, the group health plan could not be an employee welfare benefit plan under ERISA based upon *Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), cert. denied, 101 S.Ct. 1739 (1981).

It is true that a multiple employer trust is not, in and of itself, an employee welfare benefit plan. *Taggart*, 617 F.2d at 1211. However, a group health plan is not exempt from ERISA simply because a multiple employer trust is connected in some manner with the plan. *Memorial Hospital System*, 904 F.2d at 242, *see Donovan*, 688 F.2d at 1374-75; *see also, Meredith v. Time Ins. Co.*, 980 F.2d 352, 354 (5th Cir. 1993) (a court should not simply be concerned whether there exists a multiple employer trust, but whether the purchase of insurance from the multiple employer trust constitutes the establishment or maintenance of an employee welfare benefit plan). Thus, Petitioners' reliance upon the *holdings* in *Taggart* is misplaced.

Petitioners' reliance upon the *facts* of *Taggart* is also misplaced. In *Taggart*, a company obtained group health coverage through a multiple employer trust for its president/sole employee and his family. Asserting that the multiple employer trust itself was an employee welfare benefit plan under ERISA, the company and its president/sole employee brought suit under ERISA against the group health insurer to recover health benefits allegedly owing to his wife. However, the Court held that

the "bare purchase of insurance" under the multiple employer trust for the president/sole employee and his family did not establish the existence of an employee welfare benefit plan under ERISA. *Taggart*, 617 F.2d at 1211; *see also Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992) (a group health plan whose sole beneficiaries are a proprietor and his dependents cannot qualify as an employee welfare benefit plan under ERISA).

The holdings of *Taggart* were subsequently limited by the Court in *Memorial Hospital System* (which is factually indistinguishable from this case). In *Memorial Hospital System*, the Court noted that, unlike *Taggart*, that case did not involve the bare purchase of insurance by the president/sole employee of a company through a multiple employer trust. Rather, the employer had chosen to provide health benefits to all of its full-time employees through a multiple employer trust underwritten by a group health policy, and the employer was responsible under the group health policy for paying monthly premiums. The Court also noted that "the fact that [employer's] administrative functions under the policy were minimal was perfectly in keeping with its intent that [the insurer] administer the plan as well as insure it," and "there is, thus, an employer-employee plan relationship that was lacking in *Taggart*." *Memorial Hospital System*, 904 F.2d at 243; *see also Perkins v. Time Ins. Co.*, 701 F.Supp. 576, 577-78 (S.D. Miss. 1988). The Court then upheld a summary judgment that an employee welfare benefit plan had been established and maintained under ERISA since, from the summary judgment evidence, a reasonable person could ascertain the intended benefits under the group health plan, a class of plan beneficiaries, the source of

financing for the plan, and procedures for receiving benefits under the plan. *Memorial Hospital System*, 904 F.2d at 243.

Based upon *Memorial Hospital System* (which involved virtually identical facts to the facts of this case), Respondents assert that the Court of Appeals properly upheld the summary judgment that the group health plan constituted an employee welfare benefit plan under ERISA since a reasonable person could ascertain the intended benefits under the group health plan, the class of the plan beneficiaries, the source of financing for the plan, and procedures for receiving benefits as a matter of law.[3]

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[3] In addition, Petitioners assert that the group health plan is an "entrepreneurial venture" which would not be protected as an employee welfare benefit plan under ERISA. However, the group health plan is not an "entrepreneurial venture." *Compare Hamberlin v. VIP Ins. Trust*, 343 F.Supp. 1196, 1198 (D.C. Ariz. 1977) (without placing the business with an authorized insurer after an insurer cancelled its group health insurance coverage which underwrote a multiple employer trust, insurance brokers established a self-funded trust for providing limited health benefits but not extended benefits, the brokers acted as administrators of the fund for a 15% commission and this arrangement was purely an "entrepreneurial plan" to protect the business commissions they would have lost if the trust had not been restructured and continued after the insurer cancelled its group health coverage); *see Memorial Hospital System*, 904 F.2d at 242-243.

Petitioners also assert that, since J. N. McDonald was the sole proprietor of McDonald Equipment, an employee welfare benefit plan under ERISA could not be established for the purchase of insurance through a multiple employer trust and that, since a sole proprietor cannot qualify as an ERISA participant because he cannot be both employer and employee, ERISA cannot pre-empt J. N. McDonald's claims. However, J. N. McDonald's status as sole proprietor of McDonald Equipment

Memorial Hospital System, 904 F.2d at 243; *Donovan*, 688 F.2d at 1373. Furthermore, since McDonald Equipment established and maintained an employee welfare benefit plan under ERISA, Petitioners' state law claims are pre-empted under ERISA. *Metropolitan Life Ins. Co. v. Taylor*, 107 S.Ct. 1542 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1553 (1987); *Memorial Hospital System*, 904 F.2d at 245; *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760, 762 (5th Cir. 1989).

Petitioners' state law claims are clearly "related to" an ERISA plan; and, thus, those claims are preempted by ERISA.

For the first time on appeal, Petitioners have now asserted that ERISA should not pre-empt their "state law claims of fraud in the inducement, deceptive trade practices and fraud employed by insurance agents and brokers to induce the purchasers of insurance and/or ERISA plans." However, neither PILIC nor French (or the BIT) was the insurance agent or broker for the group health plan, and Petitioners did not sue them in such capacity. Also, there was no fraud inducing Petitioners into the

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or as an "ERISA participant" is immaterial, since the claims belong to Nathan and Sharyl McDonald (as the parents of Neil McDonald) as a result of the medical expenses incurred by them while the group health insurance coverage under the PILIC policy was in effect, and J. N. McDonald has no standing relative to those claims. *See Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir. 1991), cert. denied, 113 S.Ct. 68 (1992) (the plaintiff in an ERISA action must be a "participant" (or an employee or former employee who is or may be eligible to receive the benefits in dispute under an ERISA plan); *compare Meredith v. Time Ins. Co.*, 980 F.2d 352 (5th Cir. 1993); *Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178 (6th Cir. 1992).

plan at the time of the placement of replacement coverage with PILIC, since Petitioners had already been participating in the group health plan for several years. In addition, Respondents have failed to raise this issue before the Court of Appeals; and, thus, they have failed to preserve any error (if any). *See Singleton v. Wulff*, 96 S.Ct. 2868, 2877 (1976); *Youakim v. Miller*, 96 S.Ct. 1399, 1401 (1976) (Ordinarily the Supreme Court should not decide questions not raised or resolved in the lower courts).

In any event, Petitioners' state law claims (including fraud claims) clearly "relate to" an ERISA plan. This Court has dealt with the scope of ERISA pre-emption on numerous occasions. ERISA preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in § 1003(a) of this title and not exempt under § 1003(b) of this title." 29 U.S.C. § 1144(a). A state law "relate[s] to" an ERISA plan "if it has connection with or reference to such a plan." *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, 583 (1992); *Shaw v. Delta Airlines, Inc.*, 103 S.Ct. 2890, 2900 (1983). The "deliberately expansive" language of the pre-emption clause is "designed to establish pension plan regulation as exclusively a federal concern." *Ingersol Rand Co. v. McClendon*, 111 S.Ct. 478, 482 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1555-57 (1987). Under § 514(a), ERISA preempts any state law that refers to or has a connection with ERISA plans (if it does not fall within § 514(b) exception) "even if the law is not specifically designed to effect such plans, or the effect is only indirect," 29 U.S.C. § 1144(a); *see District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. at 583; *Ingersol Rand Co. v. McClendon*, 111 S.Ct. at 483, and even if the

law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S.Ct. 2380, 2389 (1985).

As noted above, Petitioners asserted various claims under state law (including claims of breach of contract, breach of fiduciary duty, breach of the duty of good faith and fair dealing, fraud and violations of the Texas DTPA and Texas Insurance Code), and all of these state law claims related to the placement of the replacement coverage with PILIC or the setting of premiums and the handling of claims in the group health plan. (R.III 434-462)

Clearly, Petitioners' state law claims "relate to" the administration of the group health plan; and, as such, those claims clearly have "a connection with or reference to such a plan." *See Ingersol Rand Co. v. McClendon*, 111 S.Ct. at 483-484 (state law claim that an employer wrongfully discharged employee to avoid paying benefits under employees' pension fund "relates to" ERISA plan and therefore is preempted by ERISA); *FMC Corp. v. Holliday*, 111 S.Ct. 403, 407-409 (1990) (ERISA preempted application of state anti-subrogation law which precluded reimbursement from a claimant's tort recovery for benefit payments paid under an ERISA plan); *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. at 1558 (state law claim of bad faith relating to improper processing of a claim for benefits under an ERISA plan is preempted). Accordingly, the lower courts did not err in holding that ERISA preempted Petitioners' state law claims.

Petitioners did not assert any claims of wire fraud or mail fraud or RICO violations.

Petitioners suggest that PILIC and French committed wire fraud, mail fraud and RICO violations under federal

law and that "the Fifth Circuit's Opinion fails to address how PILIC's violation and French's violation of other state and federal laws can be preempted by ERISA." However, Petitioners' claims of violations of state law are preempted by ERISA (as noted above). Furthermore, Petitioners did not assert any claims for wire fraud, mail fraud or RICO violations under federal law (R.II 434-462), and neither PILIC nor French committed any wire fraud, mail fraud or RICO violations under federal law. Since Petitioners did not assert any claims of wire fraud, mail fraud or RICO violations, there is nothing presented for this Court to review. *See Usery v. Turner Elkhorn Mining Co.*, 96 S.Ct. 2882, 2902-2903 (1976) (where claim was never asserted in the District Court, it would be inappropriate for the Supreme Court to consider the merits of the claim).

French (as trustee of the BIT) did not breach any fiduciary duty in placing the replacement coverage with PILIC.

The BIT trust agreement basically provided French (as trustee of the BIT) with the discretion in selecting and maintaining the group health coverage to be provided through the BIT (Ex. 4, Article VII). In fulfilling his duties as an ERISA fiduciary, French owed a duty to all beneficiaries (and not just to individual beneficiaries) under the group health plan. *Williams v. Caterpillar, Inc.*, 944 F.2d 658 (9th Cir. 1991). In this case, French (as trustee of the BIT) did not breach any fiduciary duty in placing the replacement coverage with PILIC.

When he was faced with the "emergency" situation prompted by NCM's notice of intent to terminate its group coverage, French conducted an immediate search

for insurers to place the "block of business" (including approximately 4,000 certificate holders) so there would be continuing coverage under the group health plan. (Tr.II 172-173, 176-177) After interviewing several insurers, French decided to place the replacement coverage with PILIC. (Tr.II 176, 229) At that time, he could not find any closer coverage to the coverage afforded under the NCM policy (Tr.II 180), he understood that coverage under the PILIC policy was going to be tier-rated (which was common in the insurance industry) "just like everyone else based on losses"[4] (*Id.*), and PILIC was an established company (102 years old) which was interested in expanding its business in this area. (Tr.II 176, 179) It is undisputed that French had no pre-existing relationship with PILIC, and he did not receive any compensation (cash, stock, etc.) as a result of the placement of the replacement coverage with PILIC, although PILIC allowed IRM (the administration company organized by French) to handle the administration of the group health plan (a common practice in the industry) for a set fee (Tr.II 175-176).

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[4] Incidentally, French and his family as well as the employees and dependents of IRM (the administration company organized by French) were also provided the same coverage under the group health plan and were subject to the same re-rating of premiums formula, and their premiums were adjusted according to the tier re-rating structure by NCM and, later, PILIC (Tr.II 174-175, 250-251).

Also, contrary to Petitioners' assertion, French did not testify that PILIC's tier rating schedule was designed to force small businesses (like McDonald Equipment) to drop their coverage if they experienced a catastrophic loss (Tr.II 198), the Koppel & Co. report did not advocate this "policy," (Ex. 8) and PILIC did not rely upon the Koppel & Co. report relative to tier rating for the group health plan. (Tr.I 235, 237)

Contrary to Petitioners' suggestion, French did not choose PILIC only because they were willing to allow IRM to administer the group health plan; rather, he chose PILIC because they were willing to accept the "block of business" (including approximately 4,000 certificate holders at the time) (Tr.II 207-208), and PILIC provided the best available replacement coverage under the circumstances (Tr.II 178). Also, French timely notified all certificate holders (including Petitioners) regarding the change in coverage. (Ex. 61) In any event, PILIC was (and remains) solvent, and PILIC paid all of Petitioners' covered claims. (Tr.II 247)

Under the circumstances, French (as trustee of the BIT) did not breach any fiduciary duty owed to the plan in placing the replacement coverage with PILIC. *See Williams*, 944 F.2d at 664-665 (pension and medical plan managers did not breach their fiduciary duties by offsetting accrued retirement benefits following change in certain former employee's employment status; and, former employees, who did not ever request any plan description, could not seek damages for alleged failure of plan managers to furnish plan descriptions); *United Paper Workers International Union AFL-CIO, CLC v. Jefferson Smurfit Corp.*, 771 F.Supp. 992 (E.D. Mo. 1991) (employers did not breach their fiduciary duty in increasing retirees' group medical premiums and reducing medical benefits where plan reserved to employers the right to modify the plan).

Petitioners continue to accuse French of having a conflict of interest when he placed the replacement coverage with PILIC because IRM (the administration company organized by French) was allowed to administer the

group health plan (for which IRM received a commission), and when he assigned his trustee duties to three individuals (PILIC employees) and sold the business under the BIT handled by IRM to PILIC.

A fiduciary charged with self-dealing in a group health plan must either prove by a preponderance of evidence that the transaction in question fell within an exemption, or he must prove by clear and convincing evidence that compensation received was for services rather than for transactions involving assets of the plan. *Lowen v. Tower Asset Management, Inc.*, 829 F.2d 1209 (2nd Cir. 1987); *Wildbur v. Arco Chemical Co.*, 74 F.2d 631 (5th Cir. 1992), reh'g denied, 979 F.2d 1013 (5th Cir. 1992); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011 (5th Cir. 1992); *Vassuer v. Haliburton Co.*, 950 F.2d 1002 (5th Cir. 1992). However, a fiduciary is not subject to liability under ERISA if he terminates his relationship with the plan before playing any role in transactions otherwise denied to fiduciaries by ERISA. *Id.* at 1219.

As noted above, French (as trustee of the BIT) had no pre-existing relationship with PILIC, and he received no consideration when he placed the replacement group health coverage with PILIC in 1988. (Tr.II 175) However, PILIC (like NCM) did allow IRM (the administration company organized by French) to continue to act as third-party administrator for the group health plan (a common industry practice) for a set fee. (Tr.II 21) Later, in 1989 (about one and a half years later), PILIC acquired the business under the BIT handled by IRM (the administration company organized by French) for cash and stock in Provident American Corporation (the parent company of PILIC). (Tr.II 186, 213) French was later appointed to the

Board of Directors of Provident American Corporation. (Tr.II 21) However, this transaction occurred after French resigned as trustee and assigned his trustee duties to three individuals (which were later assigned to a trust bank); and, after PILIC acquired IRM, the situs of the BIT was moved from Georgia to Mississippi, and the administration of the group health plan was transferred from IRM (a third-party administrator) to in-house at PILIC (which is not uncommon). (Tr.II 182-189) These subsequent transactions (which occurred about one and a half years after the placement of the replacement coverage with PILIC) had no effect on French's decision to place the replacement coverage with PILIC (*Id.*), and the transactions did not effect any change in coverage under the group health plan or any change in the handling of the claims. (*Id.*)

Under the circumstances, French did not have a conflict of interest when he placed the replacement group health coverage with PILIC in 1988. Also, IRM was clearly compensated for "services other than transactions involving assets of the plan," and French has no liability for breach of fiduciary duty under ERISA since he terminated his relationship in the plan before selling the business under the BIT handled by IRM to PILIC.

Neither PILIC nor French breached any fiduciary duty to Petitioners relating to the setting of premiums or in the handling of the group health plan.

Petitioners basically assert that PILIC and French breached their fiduciary duty in failing to disclose to them the basis upon which premiums would be adjusted. However, the record shows that tier re-rating was commonly employed by many insurers at the time to adjust

premiums under similar group health plans (Tr.II 90, 168, 180-181), tier re-rating is both fair and reasonable (Tr.II 190, 271-272), both PILIC and French understood that NCM had employed class or tier re-rating in adjusting the premiums for the similar group health coverage under the NCM policy (Tr.II 61, 80, 180, 223), and PILIC was probably more lenient than NCM in re-rating (Tr.II 67-68). In addition, there are a number of practical reasons why re-rating information is not disclosed to policy holders (Tr.II 105, 224-225; Tr.III 2-3), and it is not common for marketing and administration personnel to disclose an insurer's rating system (which is proprietary). (Tr.II 303) Contrary to Petitioners' assertion, the tier re-rating structure employed by PILIC (and NCM) did not "pick on any one particular [employer] group to knock them out of a plan. [All employer groups were] treated identically the same insofar as rating was concerned." (Tr.II 198-199) In addition, tier re-rating "does not work to allow an insurer to ultimately recoup all of claims paid" (Tr.II 271), and PILIC did not recoup all of the claims it paid (Petitioners were paid approximately $360,000.00 in benefits for Neil McDonald, whereas McDonald Equipment paid only a few thousand dollars per month in post-accident premiums for all of its employees and their dependents (including Petitioners)). (Tr.II 271-272; *also,* Tr.I 189)

Petitioners also continue to complain that French misrepresented that the PILIC policy was an "assumption" of the NCM policy. However, it is undisputed that PILIC's policy was never advertised as an "assumption" of the NCM policy (but was clearly a new replacement policy). (Tr.II 279-280) In addition, French and PILIC never committed to duplicate NCM's coverage, and the

PILIC policy provided substantially similar coverage (with only insignificant differences) (as noted above).

Petitioners also complain about the transfer of the trustee duties (and benefit committee) from French to three individuals (and later to a trust bank), the transfer of the administration of the group health plan from IRM to in-house at PILIC and the transfer of the situs of the BIT from Georgia to Mississippi. However, it is not uncommon for an insurer to administer its own claims in-house, and PILIC wanted control of the administration of the group health plan to better serve its employer groups. (Tr.II 122-124, 182-186) In addition, the transfer of administrative duties from IRM to PILIC did not effect any change in coverage; there was improvement in the servicing of the claims following the transfer of administrative duties; the transfer of the trustee duties (and benefit committee) did not effect any change in coverage; and, the transfer of the situs of the trust also did not effect any change in coverage. (*Id.*) Furthermore, the record shows that all of Petitioners' claims through the date of the termination of coverage (March 31, 1991) were paid. (Ex. 41; Tr.II 145; *see* Tr.I 64, 119, 174)

Petitioners continue to note French's failure to appoint two members to the Benefit Committee. However, this failure was inconsequential, because the PILIC policy provided (and continues to provide) substantially similar coverage to the coverage afforded under the NCM policy through the BIT. (Tr.II 276; *see* Tr.II 146-159, 193-198, 281)

Accordingly, Respondents assert that the lower courts did not err in holding that neither PILIC nor French breached any fiduciary duty owed to Petitioners in this case. *See Williams*, 944 F.2d at 664-667.

Petitioners did not show any breach of any fiduciary duty which resulted in a "loss to the plan" as required by § 1109(a).

As noted above, the Court of Appeals held that, even if French had an obligation to disclose PILIC's re-rating schedule, Petitioners failed to prove a "loss to the plan" as required by 29 U.S.C. § 1109(a). *McDonald v. Provident Indemnity Life Ins. Co.*, 60 F.3d at 237. The Court of Appeals noted that, in *Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. 3085, 3089-90 (1985), this Court interpreted the "loss to the plan" language in § 1109 to limit claims of breach of fiduciary duty to those which inured to the benefit of the plan as a whole rather than to individual beneficiaries.

Clearly, French (as trustee of the BIT) did not breach any fiduciary duties "to the benefit of the plan as a whole rather than to individual beneficiaries," and there was no "loss to the plan" which is required for any claim of breach of fiduciary duty under § 1109. *See Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. at 3089-90.

In any event, Petitioners have not raised this issue in their Petition; and, thus, Petitioners have waived any resulting error (if any). *See Chandris, Inc. v. Latsis*, 115 S.Ct. 2172, 2182 fn. 1 (1995).

CONCLUSION

Absent any "special and important reasons" and any error committed by the lower courts, *see* Supreme Court Rule 10.1, this Court should decline to exercise jurisdiction over this case and should deny the Petition for Writ of Certiorari.

Respectfully submitted,

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APPENDIX I

RELEVANT STATUTES

§1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

§1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and,

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

§1109. Liability for breach of fiduciary duty

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

(b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this subchapter if such

breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

§1132 Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

§1144 Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.